Rural Health Newscast

California Rural Health Policy Council Office
Health & Human Services Agency
Grantland Johnson, *Secretary*

State of California
Gray Davis, *Governor*

VOLUME IV, NUMBER 3 | PAGE 1 | OCTOBER 13, 2000

IN THIS ISSUE...

Tuesday, November 28, 2000

Time: 4:30 p.m. - 6:00 p.m.
Ontario Convention Center, Ontario, CA.
Held in partnership with the California State Association of Counties Health and Human Services Policy Committee, which meets from 2:30 p.m. to 4:30 p.m.

An Interview with David Carlisle, M.D., Ph.D., Director of the Office of Statewide Health Planning and Development

Recently appointed director by Governor Davis, Dr. David M. Carlisle was formerly on the faculty of the U.C.L.A. School of Medicine, and a researcher with RAND. In addition to his directorship of the Office of Statewide Health Planning and Development, Dr. Carlisle serves as a volunteer physician at the Venice Family Clinic in southern California.

CRHPC: As a volunteer provider in a clinic for more than fifteen years, what do you see as the greatest barrier to access to care for patients?

Dr. C: The greatest barrier continutes to be access to mainstream health insurance. Medi-Cal and other programs such as Healthy Families have helped. The Governor and the Administration are exploring various measures to further improve access to health care for all Californians. The other side of the coin is that many insured residents still face access issues because we lack sufficient numbers of providers to care for our population.

CRHPC: What is the biggest frustration for you as a provider of health care in a clinic?

Dr. C: The inability to refer patients for the additional or specialized services they need because of lack of specialists, long distances patients must travel to access specialists, or consultants not willing to provide such services to clinic patients.

CRHPC: What issues concern you about health care delivery in rural areas?

Dr. C: California has very unique health care delivery challenges in its rural communities: differences in geography and weather, lack of providers, deteriorating infrastructure, and seasonal fluctuations, such as tourism, to name a few.

CRHPC: What do you see as the role of the California Rural Health Policy Council in addressing some of these issues?

Dr. C: First, I was impressed by the providers' presentation of their issues and questions at the recent CRHPC public meeting. I understand that the CRHPC public meeting is the forum in which providers have direct access to some of the higher levels of state government. I see the CRHPC as the coordinator of dialogue between departments and collaboration with outside organizations, which can sometimes effect quicker and better solutions. The CRHPC members strive to unite State policy direction through the Council.

CRHPC: What are your immediate plans to address rural health issues?

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Dr. C: Before snowfall begins, I will be touring rural facilities in California, beginning with the northeast section of California, to personally experience what health care in rural areas is like and to interact with the providers.

I will also work to augment the Rural Health Services and OSHPD capital grants programs, improve workforce issues, promote Cal-Mortgage loan insurance opportunities for nonprofits, and do my part to improve access to health care for rural residents with each opportunity that comes before me.

Grants Reminder!

The California Rural Health Policy Council's Rural Health Services Small Grants Program application must be received by 5:00 p.m. on Friday, October 27, 2000 at the Office of Statewide Health Planning and Development, 1600 9th Street, Room 433, Sacramento, CA 95814.

The Office of Statewide Health Planning and Development's Capital Grants RFA was made available October 13th and the application is due December 4, 2000. To obtain the RFA, download it from the CRHPC's web site at www.ruralhealth.ca.gov, or call 800/237-4492 or 916/654-3491, or e-mail Kathleen Maestas at kmaestas@oshpd.state.ca.us to request a copy.

California Rural Health Policy Council July 14, 2000 Public Meeting Summary

The third CRHPC public meeting of 2000 was held on July 14, 2000 at the Lake Arrowhead Resort, Lake Arrowhead, CA.

A summary of the public meeting follows.

Brenda Klutz, Deputy Director, Licensing and Certification (L&C), Dept. of Health Services - Updates and Issues

♦ ***Licensing****:*
A California health facility is required to have a license to operate unless it is a government entity and a few other exceptions.

♦ ***Surveys:***
The Health Care Financing Administration (HCFA) contracts with DHS to do the surveys for Medicare and Medi-Cal (Medicaid) reimbursements.

♦ ***Aging with Dignity Initiative:***
Promotes quality of care; home / community-based care and recognizing that people need a choice.

Includes a $500 tax credit for those who are caring for people with long-term illnesses at home; increased wages for in-home support service workers; expanding Medi-Cal for the aged, blind and disabled which provides medical coverage up to 100% of the federal poverty level; senior wellness education campaign, senior housing information support center; $50 million for recruitment and retention of direct care workers in nursing homes and in-home supported services; award for exemplary nursing homes which provide cash for staff bonuses; more than a 10% increase in Medi-Cal reimbursement rates to skilled nursing facilities; and additional resources for L&C to expand the Focus Enforcement Program.

♦ ***HCFA introduces new Federal Enforcement Regulations:***
400 facilities may be at risk for decertification. L&C is centralizing the review of those deficiencies that may take a facility down the decertification track. This serves a duel purpose in looking at a facility early and recognizing what difficulties are present. It provides for internal quality assurance on a statewide basis.

♦ ***Revised Informal Dispute Resolution process*:**
If there are deficiencies in which actual harm, substandard quality of care, or immediate jeopardy are charged, a face-to-face meeting will be provided to appeal survey findings.

♦ ***Exit Conferences:***
Requires that these conferences be taped.

♦ ***End of Life Initiative:***
Recognizes resident, patient, client and individual preferences. Staff in place to focus on the wishes of the patient.

♦ ***Best Practices Cycle:***
Recognizes many models of excellence in nursing homes and other long-term health facilities.

♦ ***Skilled Nursing Technical Assistance Unit:***
Only term nurses staff. Available to skilled nursing facility Operators. Questions are answered such as how to do an innovative model and still comply with state and federal requirements. Also a source for interpretation of standards. This service is free of charge.

♦ ***Hospitals:***
L&C meeting with major hospitals every other month. Providers are encouraged to bring issues forward through the various associations, and through the Rural Health Policy Council.

♦ ***AB 394*:**
Minimum nursing staff ratios in hospitals. Drafts are in process from various sources. The target for regulation is by the end of 2002.

♦ ***Reporting Medical Errors*:**
Goal is to reduce mistakes by 50% over the next 5 years. Plan for a nationwide system to report medical errors. Pressure will be put on the states to adopt report-

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ing requirements in the next 3 years.

Medication error bill is currently going through the process. United States Veterans Administration hospitals have implemented a system where reporting medical errors is not attached to specific practitioners. This is dealing with the issue of the error and not necessarily who caused it. L&C will look at this system's implementation and applicability.

♦ ***Critical Access Hospitals:***

The Chico and San Bernardino Offices will be conducting the Critical Access Hospital surveys. Estiamtes are that 15 hospitals will qualify for Critical Access Hospital designation. OSHPD Rural Health Program facilitates program coordination and reviews the applicatiohs. When L&C receives them, they are scheduled for surveys. Sruveys are scheduled 2 weeks in advance of then they are announced. The first two surveys will be training surveys to ensure protocols are followed in the survey process.

♦ ***End Stage Renal Dialysis (ESRD) Centers:***

HCFA's enhanced survey tool, focuses on patient rights, social services, care planning, transplantation evaluation, ethigen therapy, and how the ESRD handles difficult patients. The Federal call letter was received, and they are required to survey at least 1/3 of all ESRDs in the state.

♦ ***Ambulatory Surgery Centers (ASC)*:**

HCFA received several complaints regarding complex surgeries and other care problems at ASCs. The San Francisco regional office selected 13 ASCs for special surveys. Only one of the 13 was found to be in substantial compliance.

♦ ***Home Health Agencies*:**

HCFA is in the process of developing enforcement regulations similar to what exists for nursing homes. (Medicare reimbursement)

♦ ***Licensing Applications:***

Applications for developmentally disabled facilities are being shortened and streamlined.

♦ ***E-government*:**

Will make use of technology in the future and put the following information on-line: licensing applications; information on nursing home compliance records, which includes substantiated complaints and citation histories (this is required by legislation); list of all facilities which L&C license and certify; policies and procedures; facilities letters; consultant newsletters; and more.

♦ ***Shared governing bodies and medical staff:***

There is no prohibition in state or Federal law against having a common governing body or medical staff. Hospitals are not all the same due to policy and procedures, equipment, and medical procedures that may be different in each hospital. L&C needs to see that the governing body and the medical staff are making decisions that reflect the particular characteristics of individual hospitals. This includes bylaws.

Diana Ducay, Deputy Director, Audits & Investigations (A&I), Department of Health Services - Update and Issues

Audits and Investigation has four Primary Roles:

♦ Financial audits

Financial audits of hospitals, nursing homes, clinics and managed care facilities. Included in long-term care audits this year, the program will be also review wage pass-through to ensure facilities have passed on money to direct care staff. There is a 10% penalty to those facilities that did not pass on the funds.

♦ *Investigations*
- Beneficiary fraud
- Preliminary investigation for provider fraud
- Provider special services

♦ *Medical review*
- In-house medical staff which looks at utilization of physician services
- Review provider fraud
- Case development
- Non-emergency medical vans certification
- Quality of care in managed care

♦ *Internal Audits*
- Audits the Department of Health Services
- Mandatory audits

♦ ***Cost audits of Federally Qualified Health Centers (FQHCs):***

Concerns and confusion with the Q&As involving HCFA and Health Resources and Services Administration (HRSA), especially on the part of the clinics. Q&A will be held pending further discussion and involvement of HCFA and HRSA. They will be re-released at a later date. A&I will follow current policy and procedures until the Q&As are released.

♦ ***Renegotiation of the LA 1115 waiver:***

Los Angeles County will be granted FQHC status for their county clinics and the clinics with which they subcontract. Effective date 7/1/00. Will be an influx of 80 new FQHCs in LA county. They will have 5 years to comply and officially become FQHCs.

Past Issues:

♦ ***Inconsistencies in audit applications and interpretation of regulation:***

Q&As will have guidelines for both the clinics and the audit staff. Will continue working on it and try provide a clearer definition and

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clearer direction. Desk audits have been the standard for the past year with a few exceptions. Cost report training has been provided to the clinics for the last few years. More training will be available in the future. Training for office staff is also being done to familiarize them with the special audit processes relating to clinics.

Anytime you call in and have your question answered verbally, A&I is to follow up with an answer in writing. A&I is trying to avoid audit exceptions to audits the clinic may have thought were answered two years prior. Written answers will give clinics a complete answer and documentation. This is important especially in regard to reimbursement, correct interim rate, etc.

♦ ***Withholds/appeals/money owed to you:***

After an audit is completed and an action notice has been issued, it is sent through the Third Party Liability (TPL) branch which is Medi-Cal, not A&I. TPI will send out a demand letter to the clinic and request a response in 60 days. Within the 60 days the clinic can contact TPL and ask for a repayment agreement. If TPL doesn't hear from the clinic in 60 days, they will place a 100% withhold on the account. Recovery will continue even through the appeal process, but that will not be in place for another 30 days. So the clinic has 90 days from the original demand letter before any withhold is placed on their Medi-Cal funds. The confusion is that clinics think that if they appeal the audit, the recovery will be stayed.

♦ ***Recalculations:***

Have been a problem in the past. A&I now does recalculations. Once A&I receives the appeal, we would like to get the reimbursement back to you within 30 to 45 days.

♦ ***Medi-Cal Fraud and Abuse:***

This is a major problem in the state. The Governor is taking this problem very seriously. It was one of his three focuses in his State of the State address. DHS has increased the number of staff to review fraud and abuse, but the primary goal is to develop policy and procedure to prevent fraud. Need to keep fraudulent providers from enrolling in the program, but still allow a reasonable amount of time for honest providers to enroll.

The Primary focus of fraud has been on durable medical equipment, non-emergency medical transportation, prosthetics and orthodontics, pharmacies, and labs. They did not focus too heavily on physicians. A&I thought providers were doing well with the medical community until March, when a KABC story was released about the amount of fraud that was occurring in LA County.

The concern of DHS is that fraud is moving to a more medical setting. Medi-Cal beneficiaries are at risk from medical tests to which they are subjected. They don't understand the possible health risks associated with blood draws under unsanitary conditions; the risks of multiple EKG's, X-rays, and a variety of other tests preformed on them, with as many as 10 to 15 procedures in a setting. These tests are conducted multiple times throughout the day for a $35 payment to the patient, or items like tennis shoes, food, etc. Some patients have been taken to a dentist office and have had their teeth drilled when it was not necessary.

This fraud does not only include the homeless, but it includes children. They have instances of children being picked up in a van. DHS wants the public to know that there are safe places for them to go for health care and that they can make the distinction between "clinics" not providing health care and the safe and quality care provided at community and rural health clinics.

A Fraud Line is available for the public. This is an automated system. The caller will receive a return call within 24 hours if they leave a telephone number and they can also leave their complaint anonymously.

The fraud in LA involved a medical setting, so fraud investigators were teamed with a medical professional Over 850 providers and over 2,400 beneficiaries were involved in the investigation. Not all the 850 physicians were fraudulent since the Medi-Cal beneficiaries were going to get real care at some place. Teams were sent out to review each of these "clinics."

The fraud and abuse project was instituted in March in LA County. Over 150 providers have been placed on withhold and temporary suspension. They can no longer provide Medi-Cal services until a complete investigation is made. The above investigation alone will save the state about $75 million by removing providers from the program.

A&I is not looking for mistakes, but looking for fraud that might be potentially harmful for the Medi-Cal beneficiary. They want to ensure safe and quality health care for Medi-Cal beneficiaries.

Public Comment

♦ Critical Access Hospitals (CAH) must have less than 15 beds and be 35 miles from another facility in order to participate in the program. Medicare reimbursement is cost-based, but it isn't enough. Only 5 hospitals will end up in the program.

One CAH eligible hospital stated that feasibility to become a CAH is not good. Medicare in-

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creased reimbursement would only amount to an additional $25k. It would not be feasible to invest resources to go through process (survey, etc.) for this amount.

Governor Davis vetoed a bill that would have increased Medi-Cal reimbursement to Medicare levels for the CAH program.

Need DHS and OSHPD on record that they are in support of the program.

♦ Problem of Metropolitan Statistical Area status for a whole county that has rural areas.

♦ HCFA doesn't recognize state rural hospitals, only federal.

♦ Title 22 is out of date. L&C has been allowing some flexibility, but decisions are made at the district office level. There are inconsistencies between district offices applying regs to hospitals. Needs central office to make decisions.

♦ Rural hospital has 1800 EMS transports a year; needs to stay open. Could not transport these patients "down the hill."

♦ L&C has stated that 85% of resources go to skilled nursing facilities or to non-acute care facilities.

♦ L&C's lack of a survey agenda during the CALS process. The Joint Commission and CMA need to come to hospital with an agenda so the hospital knows what to expect and with whom they need to meet It makes it difficult for rural hospital to accommodate L&C's needs.

♦ 83% of San Bernardino County land is federal, which is unfunded. The county is not compensated for the health care it provides there. Interstate 40 and 15 run through the area, and people traveling through are from both coasts. The county cannot respond to them in a timely manner and it struggles to meet standards to provide care. Need s $500k in the county budget to take care of those on federal land. Need state and federal governments to have stake in it.

♦ Many industries in rural California are dependent on health care continuum. Current legislation speaks to maintenance of effort issues to continue to support rural infrastructure; there is a possibility that bills may not pass and would shift uninsured dollars to urban areas.

♦ Important that impression of fraud not be applied to everyone. Some clinics should be identified as quality clinics, not just identify the bad ones.

♦ HPSA, MUA, MUP boundaries should reflect utilization patterns, care seeking patterns, rural market areas.

♦ Difficult to recruit providers because of rates paid under government programs. Healthy Families is not picking up the slack from the drop in Medi-Cal enrollment.

♦ The definition of rural needs to define frontier. 11 persons per square mile is suggested by providers.

♦ Clinic provider continues to have a problem getting a radiology provider number.

♦ Mental Health Services needs to include Marriage, Family, and Child Counselors as freestanding provider types because of the difficulty attracting Licensed Clinical Social Workers to rural areas.

♦ Cash flow problem because clinics have to wait until cost settlement to get money for salaries.

♦ Concern facing medical community and Emergency Medicall Services (EMS), particularly 911. In the Vision 2000 Report, the Emergency Medical Services Authority supports having 911 providers call insurance carrier before sending emergency services. Potentially life threatening. Outside of scope of the services EMS is committed to provide.

The issues testifiers bring before the CRHPC are referred to the appropriate department and monitored to ensure that a response is sent to the testifier.

Health Resources and Services Administration New Technical Assistance Service

HRSA has a toll-free number (877/832-8635) for their grantees and other safety net providers to access the agency's Managed Care Technical Assistance Center (MCTAC) for on-site assistance and workshops about managed care issues such as:

• Training clinicians and medical directors to deliver high-quality, cost-effective care to Medicaid and medically underserved people in a managed care system.
• Negotiating capitation rates and reimbursement.
• Building relationships between public health and managed care.
• Securing and negotiating the best managed care contracts.
• Improving management information systems to serve Medicaid-covered patients.

MCTAC technical assistance services and workshops will include expert advice from managed care senior executives about capitation management, contracting for managed care enrollees, financial analysis and monitoring, medical management/utilization review, and management information systems.

The service is also open to other safety net providers such as public hospitals, state and local public health departments, and Medicaid managed care plans.

MCTAC is managed by the HRSA Center for Managed Care

For more information, call the toll-free line or fax: 703/528-7480;

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or send an e-mail to: hrsa_mctac@si.com)

Health-e-App for Low-Income Children

The Managed Risk Medical Insurance Board (MRMIB) has announced Health-e-App, the first fully automated, web-based application for enrolling low-income children in public health insurance programs. It will streamline the application process and speed up the time it takes for eligible children to gain access to care.

In cooperation with the Department of Health Services and MRMIB, the Managed Care Policy Institute and the California Healthcare Foundation are preparing to test the application. The goal is to have Health-e-App ready for statewide implementation by the end of the year.

For more information on Health-e-App, and to view a narrated, self-paced demo of the application, visit the web site at:

calhealthcare.unitymail.net:81/UM/T.ASP?A41.291.16.1.2451

National Rural Development Partnership

The CRHPC has been invited to become a member of the National Rural Development Council (NRDC) Partnership Healthcare Taskforce. The NRDC identifies program duplication and gaps in service to rural areas; builds collaboration and coordination among federal-level rural initiatives and programs; provides input on potential consequences for rural communities during policy and regulation consultations with federal agencies and Congress; resolves unintentional federal policy or regulatory impediments to successful rural development efforts; provides a forum for the continuing dissemination of information on the status and condition of rural communities; and sustains support at the federal level for the efforts of State Rural Development Councils. Their web site is:

http://www.rurdev.usda.gov/nrdp

Jobs Available Update

Current Listings:		Positions Filled:	
By Practice Setting:		By Practice Setting:	
Hospitals	40	Hospitals	327
Clinics	39	Clinics	475
Public Health	25	Public Health	306
LTC/SNF	3	LTC/SNF	23
Mental Health	4	Mental Health	139
By Type of Position		By Type of Position	
Patient Care	63	Patient Care	740
Ancillary	10	Ancillary	147
Administrative	38	Administrative	383

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Published by the
California Rural Health
Policy Council Office

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Dated Material Inside!